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ABSTRACT

This monograph analyzes the recruitment and retention of Asian Americans in University Affiliated Programs (UAP), which train personnel for the provision of health, education, and social services to people with developmental disabilities. It is designed to assist UAP faculty and staff at each UAP to develop a comprehensive plan to increase the participation of minority faculty and trainees, specifically South-East Asians (SEAs) who entered the United States since 1975 from Vietnam, Cambodia, and Laos. The monograph discusses cultural identifiers and terms of reference, gives a historical overview of the SEA population, and provides information on the following topics: demographics of the SEA-American population (including numbers of refugees arriving by year, cultural grouping, and birth rate); educational experiences of SEA- American students (including exposure to education prior to coming to the United States, cultural values, and college enrollment); health issues (including culturally influenced health behaviors and health care service utilization); and general characteristics of the SEA-American population (including non-assertiveness, embarrassment at receiving praise, "loss of face," diet, religion, community leadership, and family). An exemplary recruitment and retention approach is outlined, with eight main components such as outreach to SEA-American community leaders and financial, educational, and social supports for college students. Three exemplary programs are described. (16 references) (JDD)

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Recruitment & Retention OF MINORITY TRAINEES

in University Affiliated Programs

EC 233245

ASIAN AMERICANS

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THE RECRUITMENT AND RETENTION OF MINORITY TRAINEES IN UNIVERSITY AFFILIATED PROGRAMS

ASIAN-AMERICANS

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FOREWORD

This monograph is one of a four-part series on the recruitment and retention of minority trainees in University Affiliated Programs (UAPs). Each monograph discusses the social issues and strategies related to the recruitment of a particular minority population; Hispanics, African-Americans, Asian-Americans, and Native American Indians.

The monographs were developed as part of a consortium initiative that involved the UAPs at Birmingham, Alabama; Omaha, Nebraska; Portland, Oregon; Vermillion, South Dakota; Dallas, Texas; and Madison, Wisconsin and the American Association of University Affiliated Programs (AAUAP). The consortium initiative was supported in part through a grant from the Administration on Developmental Disabilities (ADD), Office of Human Development Services. Other products developed through the ADD grant to the consortium include brochures, posters, bookmarks, and a video-tape that can be used by all UAPs and their affiliating universities to recruit minority students. In addition, a national conference was held in June 1990 at Madison, Wisconsin to design operational plans for ten UAPs across the country to recruit and retain minority trainees. These operational plans will guide the development and implementation of a state-wide recruitment endeavor that will be done through collaboration with each UAP's affiliating university, feeder colleges, and/or state agencies. All of the products developed through the project and the conference report will be disseminated to every UAP in the network.

The purpose of the monograph series is to provide information and resources that can be used by the faculty and staff at each UAP to develop a comprehensive plan to recruit and retain minority students for their UAP training programs. It is expected that this series also will be a useful guide for the faculty and staff of each UAP's affiliating university and feeder colleges and for the policy-makers and administrators of the state agencies that are responsible for the provision of services to people with developmental disabilities.

The need for increased numbers of minority trainees in our UAP training programs is obvious. There is a growing and endemic personnel shortage within the health, allied health, social and education professions across the country. Furthermore, it is anticipated that about 500,000 higher-education faculty will have to be replaced by the year 2005 (Bowen and Schuster, 1986). As the supply of students decreases, the demographics of the U. S. population also is changing. The predicted rate of growth within the U. S. for the majority population is 3.2 percent; whereas the growth rate for all minority populations is 12.3 percent (U. S. Bureau of Census, 1989). Given the changing demographics of the country, the greatest resource potential for meeting personnel needs in the future will be the recruitment and retention of minority trainees.

At this point in history, the participation of minority faculty and students in the field of developmental disabilities is a matter of survival for the UAP training programs and a matter of whether health, education and social services will be available to both minority and non-minority people with developmental disabilities in future generations. The altruistic goals of some social activists to increase the participation of minorities in academia and the service professions is an anachronism. Today, the participation of minority faculty and health professions is a matter of economic necessity.

Today's UAP graduates live and work in a world that has become a global village, and the ability to work with and to serve people from different cultural heritages ia a necessary tool for all service providers, policy-makers, teachers, and researchers. When our UAP training programs emphasize an Anglo-American perspective instead of cultural diversity, both the majority and the minority trainees receive inadequate training to provide direct-care services and to provide leadership among health, education, and social service professionals regarding issues related to developmental disabilities.

The monographs will assist UAP faculty and staff to develop a comprehensive plan to increase the participation of minority faculty and trainees within their UAP training programs. Each monograph provides information regarding the demographics and educational experiences of a particular minority population and a discussion of exemplary strategies and programs to recruit those students into colleges. The series of monographs reflects the ethnic diversity among minority populations within this country.

Each monograph was developed with the advice and guidance of an advisory committee that was comprised of professionals in education and/or health who were members of the minority populations addressed by the monograph. Committee members helped to design the monograph and to maintain the integrity of the information discussed. In addition, to the Asian-American Advisory Council, Dr. Keiter consulted with a number of professionals who were working with South-east Asian-Americans or who were at one time refugees from South-east Asia.

As the editor of this series, I want to express my sincere appreciation to the authors for their outstanding efforts and endurance, to the people who worked with us as advisors to the project, and to the administrative and support staff of the Waisman Center UAP for their notable contributions to this undertaking.

Sincerely,

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INTRODUCTION

An Asian-American population was present in 1776 during the founding of the United States of America. The Asian-American population is a heterogenous group of people. It includes people whose families originally immigrated to this country from Burma, Cambodia, China, India, Indonesia, Japan, Korea, Laos, Malaysia, the Philippines, Singapore, Taiwan, Thailand, Vietnam, and other areas often referred to as "Indo-China" or the "Far East."

The end of the Vietnam conflict in 1975 marks the beginning of a new migration of individuals who were refugees to the United States and other countries from Vietnam, Cambodia, and Laos. This monograph is focused upon the Asian-American population entering the United States since 1975 from these three countries. The term that is commonly used to refer to these refugees is South-East Asian (SEA). SEA is an acceptable abbreviation that is also used as a term of reference for this specific sub-population of Asian-Americans.

SEA people are needed as role models and community leaders. At present, their interest in prevention and advocacy for SEA people with developmental disabilities is almost non-existent. SEA people can best be served by professionals who have an intimate and personal knowledge of the cultures, the community structures, and the economic and political backgrounds of SEA people and by professionals who know how to appropriately access and reach out to SEA people in their local communities. This monograph has two main purposes:

- to help the faculty and program staff of University Affiliated Programs (UAPs) to understand the SEA population in greater depth, and
- to provide information on methods that can be used to facilitate the recruitment and retention of the SEA population into each UAP's training program.

The ultimate goal is to increase the participation of SEAs in the field of developmental disabilities.

CULTURAL IDENTIFIERS AND TERMS OF REFERENCE

The terms South-east Asian-American or SEA are often confused and used interchangeably with the term Asian-American. The term SEA is limited to the refugees from Vietnam, Cambodia, or Laos and specific sub-cultural groups within these countries. In contrast, Asian-Americans include all of these populations and also includes people who are Burmese, Chinese, Filipino, Indonesian, Japanese, Korean, Malaysian, Taiwanese, Tai (Thai), and other people from Asia. The term Asian-American also could be used to refer to the new refugee populations in the United States who came from the eastern coast of the Soviet Union and who are of caucasian descent or Asian Eskimo.

Indo-Chinese is another term that is not used accurately to refer to SEA people. The term Indo-Chinese is usually refers to individuals who came from one of the countries colonized by the French. In a broad sense, Indo-Chinese can be used to refer to the Vietnamese who lived under French rule for many years. However, it is inappropriate to use the terms Indo-Chinese and South-east Asian interchangeably. Unfortunately, some authors continue to use the term Indo-Chinese when they really are discussing the SEA population. In this monograph the term SEA-American will be used as an identifier for SEA refugees who are now U.S. citizens.

The SEA population that has immigrated to this country over the past fifteen years is not composed of one single ethnic group. The cultural heritage of an SEA person can not be determined by his/her country of origin. Rather there are different ethnic groups within each of the three countries and also ethnic groups that transcend all three countries. The individuals from these countries have a background that varies broadly in values, beliefs, traditions, languages, religions, diets, and education. Therefore, the reader is highly cautioned not to form any stereotype impressions about the SEA-American population in this country nor about the citizens of Vietnam, Laos, or Cambodia.

The three most distinct groups of people who live in Vietnam, Laos, and Cambodia are the Hmong, the Mien (or Yiu-Mien), and the Ethnic Chinese. Both the Hmong and the Mien are primarily, but not exclusively, from the highland areas of Laos. These groups evolved from tribal or clan groups with distinctive backgrounds, languages, diets, beliefs, and child rearing practices.

The word "Mien" means "people." Some people have chosen to use the term "Yiu-Mien" or "Yiu-people" to refer to themselves. However, this term of reference is not used by all the Mien groups across the United States. In 1982, the largest population of Yiu-Mien in this country lived in the Portland, Oregon area (Knoll, 1982).

The Ethnic Chinese are a specific minority sub-cultural group that has two distinct sub-groups. The largest portion of Ethnic Chinese consists of those Chinese that moved to Vietnam, Cambodia, or Laos as managers, skilled artisans, and shop keepers during the period of industrialization which occurred in those countries after World War II. These people left China because of political conflicts in that country and the rise to power of Mao Tse Tung. The other sub-group of the Ethnic Chinese came from the small groups of Chinese that lived in the mountains along the Chinese border with Vietnam and Laos. These individuals were forced out of Laos and Vietnam with the rise of the communist governments in Laos and Vietnam, and they were not welcome in China. Thus, even the term Ethnic Chinese refers to two very diverse sub-groups in a minority sub-cultural group within the countries of Vietnam, Cambodia, and Laos.

It is important for the readers of this monograph to avoid stereotyping the SEA population and to remind themselves continually of the extreme diversity between people within the countries of Vietnam, Laos, and Cambodia and also of the sub-groups of people that exist across these same countries.

HISTORICAL OVERVIEW OF THE SEA POPULATION

The geography of the south-eastern region of Asia RANGES from low river delta to mountainous terrain. In part, the diversity of the geography of this region has contributed as much to the cultural differences among the people as anything else. The geographical contrasts of this area have led invading armies or controlling populations to hold only the lands along the major rivers and transportation ties to the outside world. The rivers serve as transportation routes and avenues to the adjoining farmland. Travel beyond the major rivers or open valleys with farmland becomes increasingly difficult due to the dense jungle, rough terrain, and heavy rainfall in the region. Groups in the more isolated areas of the region developed different cultures and were less influenced by outside cultures.

Kunstadter (1967) identified population groupings within the south-east Asian countries as dominant majority, urban minority, rural majority, and tribal groups. These were the groups that existed with the countries of Vietnam, Cambodia, and Laos prior to and during the Vietnam conflict.

The dominant majority groups were the ruling populations in these countries and had the most contact with western society. They lived along the lowland rivers THAT were easily accessible for foreign trade. The dominant majority group had a written language tradition, public schools, traditional religions, and they spoke a standard dialect (Kunstadter, 1967).

The urban minority population group shared control of the country with the dominant majority. They were bilingual in that they spoke their own dialect and the dominant majority dialect. They had a written language and used separate or special schools. They were primarily engaged in commercial and specialized occupations, such as

banking. Their cultural traditions were usually different from those of the dominant majority (Kunstadter, 1967).

The rural majority population group lived in the hills and had poor communication and transportation linkages to the dominant majority. They were subsistence farmers. Their language was a dialect of the dominant majority. However, their language was not necessarily understandable as a dialect of the majority language, and it was not recognized by the dominant majority. The rural majority had little or no contact with the formal government. There were a limited number of schools for the children. Most of these individuals were illiterate. (Kunstadter, 1967).

The tribal population groups were small clans or family units that farmed the mountainous areas using the "swiden" method of burning the jungle to clear the land. Farming was continued until the soil became poor. The family unit then moved to a new location and cleared a new section and the jungle reclaimed the spent farm. These groups were in the most remote areas of the mountains, hills, and/or dense jungle. They were away from the major rivers or transportation routes. Their language was oral and may have been preserved by a missionary. There were few schools and the individuals were basically illiterate. The economy was at a subsistence level (Kunstadter, 1967).

The governments of Vietnam, Laos, and Cambodia fell to communist armies in 1975. Many of the refugees who have settled in the United States have searched for geographic locations that more closely resemble their homeland. For discussion, the SEA refugees can be divided into three "waves of refugees." Understanding the cultural differences and different population groups within each "wave of refugees" is important as this may indicate different considerations for the recruitment and retention of SEA-American trainees and for the provision of services to SEA-American people with developmental disabilities. The remainder of the section provides information regarding each of the three waves of SEA refugees into this country.

First wave of SEA refugees. The first wave of SEA refugees consisted of political refugees that left their country just before or shortly after the governments of Vietnam, Cambodia, or Laos changed hands. Most of these individuals were the shop keepers, government employees, professionals, and others who had worked closely with the U.S. troops. Millions of the first-wave refugees also poured into other countries, including Canada, Australia, and Europe. Other individuals fled to Thailand, Hong Kong, or other Asian countries that were not under communist control.

In the United States, the first wave of SEA refugees was located temporarily on former military bases since there were no camps overseas at that time. Fort Indian Town Gap in Pennsylvania, Camp Pendleton in California, and Fort Chaffee in Arkansas were among those used (Tan, 1988). Basic adjustment to a new life style occurred within the camps, sponsors were found, and the SEA individuals were dispersed across this country.

Gradually, the SEA refugees began to relocate. They tended to move in small groups and to locate in close proximity to those of their own ethnic group. Local community associations or Mutual Assistance Associations (MAAs) were formed. In 1981, 500 MAAs had been formed, and elders, shaman, and others emerged as community leaders. There were many adjustments still to come, but resettlement had begun.

Second wave of SEA refugees. The second wave of SEA refugees were the families or relatives of the first wave (Bliatout, 1989). Many of these individuals fled to other countries or were in refugee camps or displacement camps in Asia awaiting sponsorship and money to join their families. These individuals went first to a military base in the Philippines. Basic health checks were completed while the individuals stayed at the military base and then individuals were transported directly to local communities in the United States. These individuals quickly were resettled with their families who had already been established here in this country.

Third wave of SEA refugees. SEA people who have fled their homelands since 1975 often have been sent to displacement camps in other Asian countries. Some of these refugees, or displaced persons, came to this country in the last group of refugees (Tan, 1989). In contrast to the first and second wave, the third wave of SEA refugees has spent up to fourteen years in displacement camps or other temporary housing waiting to have a new home. These individuals have significantly different problems.

The third wave of refugees are survivors of the displacement camps. These displacement camps are overcrowded with as many as 60,000 people in a square kilometer (Bliatout, 1989). Sanitation, disease, and starvation are common conditions to these camps. These individuals have had less of a problem finding a means of surviving in this country. However, there are significantly higher mental health and other health problems among the refugees in the third wave of refugees. These problems that must be dealt with through the provision of services and other supportive assistance (Bliatout, 1989; Tan, 1989; Googins, 1989).

DEMOGRAPHICS OF THE SEA-AMERICAN POPULATION

The SEA refugees have exceeded 1,000,000 individuals who have immigrated to this country since 1975. Table 1 below shows the arrival figures for fiscal years 1975 to 1988.

Table 1

Refugee Arrival Data By Fiscal Year

Fiscal Year	Refugees from SEA
1975	129,792
1976	24,216
1977	17,752
1978	20,397
1979	80,678
1980	166,727
1981	132,454
1982	72,155
1983	60,662
1984	70,591
1985	67,775
1986	62,450
1987	64,471
1988	77,500
Total	1,047,620

(Original data from, "Oregon's Arrival Population," International Refugee Center of Oregon, 1336 E. Burnside, Portland, Oregon.)

The birth rate of SEA-American women aged fourteen to forty is about double that of the average birth rate in this country. The average birth rate is 14.47 per thousand and the birth rate for the SEA-American population is 29.03 per thousand. Additionally, the SEA-American women of child-bearing age constitute a larger proportion of the that population than the proportion of all women of child-bearing age in the United States (Hopkins, 1987 and Hopkins, 1989).

Based upon the present birth rate of SEA-Americans, it is estimated that the number of births each year is over 300,000. This translates to an estimated SEA-American population in excess of 1.4 million or a little more than one half of one percent (0.5%) of the total U.S. population at present. However, as the flow of people from displacement camps and directly from Vietnam, Laos, and Cambodia continues to this country, the SEA-American population is predicted to swell to 5.0 million within the next five years (Tan, 1989).

Given the current demographics on the high birth rate among SEA-Americans, there should be a growing and continuing influx of students into the schools, colleges, and universities in this country. The faculty and program staff of the UAPs need to be ready to serve this expanding population and to intensify their recruitment efforts to bring SEA-Americans into the field of developmental disabilities.

Table 2 shows demographic data on the distribution of the SEA population in Oregon. This data is presented to illustrate how the population is divided by countries and ethnic groupings. Other demographic information from other states for specific ethnic groups are discussed later in this section.

Table 2

Cultural Grouping of SEA Arrival Population in Oregon

Group	Population Size	Percentage
Vietnamese	10,028	48.9
Cambodian	3,410	16.6
Lao	3,156	15.4
Ethnic Chinese	1,751	8.6
Hmong	1,094	5.3
Mien or Yiu-Mien	1,070	5.2
Total	20,509	100.0

(Source: International Refugee Center of Oregon, 1336 E. Burnside, Portland, Oregon)

The breakdown of the SEA-American populations and the different compositions of SEA-Americans across the country are important to note when preparing to recruit SEA-American trainees and to serve SEA-American people with developmental disabilities. In Oregon, about 80 percent of the SEA population came from the dominant majority population group of their native countries. These individuals have a common cultural heritage with others from their countries. They came from a culture that was influenced by western society, they have a common native language that is shared with their native countrymen, and they are quite possibly fluent in French and/or English, in addition to their native tongue.

The fact that 20 percent of the SEA population in Oregon comes from minority populations within their native countries is also important. In Oregon, the Ethnic Chinese, the Mien or Yiu-Mien, and the Hmong are minority populations. These groups often have a dialect or separate language that is sometimes only an oral language, and some of the parents of the children of these minority populations who are now attending public schools may be illiterate. The minority ethnic groups have clustered in areas about the country in both rural and urban settings, and they had the least exposure in Asia to western life styles, health practices, and social systems. With the exception of the Ethnic Chinese, their heritage is usually that of a subsistence farming economy.

One important aspect to consider when recruiting students or providing services to SEA-American families is the diversity of languages, cultures, traditions, beliefs, diets, and the varying abilities of these individuals. Western health care is drastically different from their cultural health care. Explanations of what will happen in the individual's native tongue are important. Also, social and education services are new and possibly unknown aspects of our society.

EDUCATIONAL EXPERIENCES OF SEA-AMERICAN STUDENTS

Education in the south-east Asian countries was heavily influenced by the French following World War II. Missionaries have provided additional educational opportunities since the early 1900s. Public education, as practiced in this country, was not universal in Vietnam, Cambodia, and Laos. Most schools were established in the areas that were easily accessible, and they were attended by the dominant majority and urban minority populations. Elementary and high school graduation was not valued by all SEA-American families and cultures.

The small cultural groups, such as the Yiu-Mien and the Hmong have had little or no exposure to education and higher education prior to coming to the United States. Today, many of these students are high school dropouts. Because of cultural traditions, many of the adolescent girls are married at the age of fourteen or fifteen to another member of their minority group. The more defiant the daughter is considered to be by her parents, the more likely she will be married at an early age and drop out of school (Doutrich and Metje, 1988). This pattern will take a while to change, but already there have been some indications that these young girls are returning to finish high school after having their children.

However, this generalization is not valid for all SEA-Americans. The educational system in Vietnam, for example, was strongly influenced by the French educational system during the extended period of French rule in that country. As a result most of the urban people in Vietnam were exposed to styles of pedagogy that are similar to those practiced in the United States. Many of the first wave of refugees, who were from Vietnam, consider the education of their children to be a primary goal for the family in order to ensure economic security for their children in the future and to provide the parents with economic security in their old age.

Bliatout (1989) maintains that sons are more likely to finish high school than daughters. Many students are working prior to high school graduation and often enter their family's business. Also, the number of adolescent pregnancies results in an increased percentage of high school dropouts (Doutrich and Metje, 1988). The ABC television program "20/20" aired a segment that suggested men in the SEA-American population are more likely to receive family support to attend an institution of higher education (May, 1989).

Rae Lee Siporin, director of admissions at the University of California at Los Angeles (UCLA), stated that the quality of Asian-American students is strong (MOORE, 1989). Of the 1988 California high school graduates, 33 percent of the Asian-American graduates met the University of California minimum eligibility criteria. This is in comparison to an overall average of 14.1 percent for all high school graduates in the state. Table 3 below shows the comparative statistics for all groups.

Table 3

Percentage of High School Graduates Meeting the University of California System's Minimum Entrance Criteria

Group	Percentage
All Graduates	14.1
Asian-American	33.3
Black-American	4.5
Hispanic-American	5.0
Anglo-American	15.8

(Source: Moore, 1989)

However, the ABC television program "20/20" indicated that Asian-American students are applying only to the top-ranked schools in the country, and they have little or no alternate plan if they fail to gain entrance to the top school of their choice. This comes from a cultural aspect of wanting the best or nothing (Bliatout, 1989). A thought pattern within the cultural experience may suggest to students and their families that if the student is rejected by one school, he or she will be rejected by all schools. Therefore, one saves pride by not risking rejection more than once.

Universities and colleges have admitted more Asian-Americans in the last year (Moore, 1989). As shown in Table 4, the number of Asian-American male doctoral students has increased steadily since 1977 but the number of Asian-American female doctoral students has remained fairly static since 1979.

Table 4
Doctoral Degrees Earned by U.S. Citizens, 1977 to 1987

Year	American Indian		Asian		Black		Hispanic		White	
	Men	Women	Men	Women	Men	Women	Men	Women	Men	Women
1977	43	22	251	88	584	432	310	113	17,011	6,054
1978	50	10	287	103	584	449	317	156	15,573	6,238
1979	56	25	311	177	551	505	308	154	15,261	6,659
1980	46	29	313	145	499	533	256	156	14,848	7,145
1981	56	29	315	150	499	514	275	189	14,458	7,521
1982	44	33	281	171	483	564	344	191	13,984	7,689
1983	50	30	312	180	412	509	288	250	13,599	8,074
1984	53	20	338	174	427	526	313	222	13,155	8,168
1985	39	56	329	187	379	533	300	261	12,778	7,926
1986	58	41	347	180	321	499	299	268	12,357	8,281
1987	63	53	367	173	317	448	332	268	12,116	8,245

(Source: Magner, 1989)

In this country during 1988, 612 (2.6%) Asian-Americans received their doctorate. This compares to 805 (3.5%) African-Americans, 594 (2.6%) Hispanics, 93 (0.4%) Native American Indians, and 20,685 (89.2%) Anglo-Americans (Magner, 1989). Statistics across all of higher education are not available, nor are statistics available to compare SEA-American students with other Asian-American students. However, Bliatout (1989) indicated that the Hmong population appear to have an increased regard for education with about 2,500 now attending college. Around the world, the number of Hmong with earned doctoral degrees has grown from one in 1975 to twenty in 1988.

The recruitment and retention of SEA-American students is a major problem due to: a) the lack of role models; b) failure to retain minority students who are at the beginning levels of higher education; c) the heterogeneity of the population; and d) the high competition among undergraduate and graduate programs for small numbers of minority students.

The families of the SEA-American students tend to direct their children toward areas of study where English is not the primary means of communication. English is a very difficult language for most SEA-American students. In most cases, English is a secondary language that is learned after entering the educational system. Parents not wanting shame for their family may advise the students to study subjects where English is less important (Bliatout, 1989). As the sub-cultural groups accept English as a primary language, this should become less of a barrier to education.

The students who do enter college are selecting fields that are expected to provide more financial security, such as engineering, mathematics, and computer science. SEA-American students are also prone to enter the business field so that they will be able to assist with the family business. The brothers and sisters of older siblings who have entered college tend to follow the role models established by their siblings and to elect the same areas of study.

The SEA-Americans are inadequately represented in the health, allied health, and the social service fields relative to their percentage of representation in the USA population in general. In part, this is related to their educational background, cultural heritage, family influences, and fact that English is often a second language. The helping professions, such as nursing, dentistry, education, medicine, or social work are seldom investigated or entered by SEA-American students.

The American Association of University Affiliated Programs (AAUAP) data indicates that only 164 Asian-Americans were trained at UAPs in academic year 1987-1988. This represents 2.6 percent of the 6,136 students trained (Smoyer and Jones, 1988). Further inquiry with the staff of individual UAP programs indicates that foreign students from Asian countries were often counted as Asian-Americans. Few SEA-American students were among the 164 Asian-American students.

There is an additional reason for the lack of representation of the SEA-Americans in the health, allied health, and social service fields. Generally, the SEA-Americans have a lack of understanding about the western health, allied health, and social service delivery systems. The opportunities for professional training and the opportunities for careers that offer geographic mobility and financial security are generally unrecognized.

HEALTH ISSUES RELATED TO THE SEA-AMERICAN POPULATION

Recent refugees have posed new health threats. New diseases and old diseases thought to be non-existent in this country have reappeared with the new refugees. Doutrich and Metje (1988) discussed the specific problem of low-birth weight and inadequate pre-natal care for the Mien and Hmong populations. Hopkins (1987) indicated that large numbers of the SEA-American population suffer from diseases uncommon to our society such as tuberculosis, hepatitis, and parasite infestations.

The patterns of health-care service utilization among the SEA-Americans are not well documented. However, qualitative and anecdotal reports suggest health services are underutilized and that there is frequent non-compliance with treatment regimens by those SEA-Americans who do seek medical care. Language, religion, traditional beliefs of the causes of illnesses, and the continual use of traditional healing arts and methods are among the major barriers to the utilization of western health, mental health, and social service care systems (Bliatout, 1989).

Ladinsky and Kuehn (1983) have developed a monograph designed to be used as an instructional training manual and resource reference for health advocates working with the SEA refugee population. In the introduction to the training curricula, they provided several examples of the influence of cultural differences on the utilization of western health care services by the SEA refugee population, as follows:

> **For example, family planning and birth control is not accepted generally among Southeast Asians, particularly the more provincial Hmong populations. However, as families struggle to adjust to present socioeconomic conditions, made more difficult by linguistic barriers or a lack of job skills, family planning may become a serious issue between individual husbands and wives. Yet, Southeast Asian culture precludes open discussion of birth control, as this is considered a very personal and private matter that is the sole discretionary domain of the family. Even an extremely objective presentation of family planning is likely to be misunderstood (pp.iv)**

> For example, traditional Chinese medicine and folk medicine in Southeast Asia is primarily dependent upon the patient's presenting symptoms. Further, when palliative treatment is employed and the patient returns to the doctor with the same symptoms, it frequently is assumed that a new disease has developed. In the U.S., medical practice relies upon patient histories, laboratory tests and physical examinations, as well as symptomatology, for the diagnosis and treatment of illness and disease. This marked difference in medical practice leads many Southeast Asians to conclude that American doctors are less competent than their eastern counterparts. Many Southeast Asians believe American doctors are too dependent upon tests, physical examinations and irrelevant questions; whereas herbalists, injectionists, and Southeast Asian doctors can adequately diagnose health problems and prescribe proper medications solely on the basis of patient observation, often without needing to physically touch the patient's body. Clearly, this is a cultural difference that can easily undermine any attempt to promote the Southeast Asian's acceptance of American medical practices (pp.v-vi).

The above mentioned health problems and the reluctance of the SEA-American to utilize the available pre-natal and health-care services can lead to or cause developmental disabilities. Although pre-natal care is regarded as extremely important for the health of babies and mothers in our culture, SEA-American mothers often do not receive pre-natal care until their third trimester. Hopkins (1987) indicated that low birth weight is a concern for the Hmong and Yiu-Mien women. Studies by Doutrich and Metje (1988) of Hmong and Yiu-Mien women suggest that they prefer small babies and purposefully restrict their diet to keep the baby small. This raises a concern in relation to low birth weight and the problems that result from low birth weight.

Doutrich and Metje (1989) also discussed the Yiu-Mien beliefs regarding unborn children. Many of the Yiu-Mien believe that the soul of the unborn child is located in different places in the house prior to the birth of the child. The exact location of the soul depends on the gestational age of the fetus. At different times the woman may not cook because the soul is located in the stove, or at another time the

woman may not want anyone to knock on the door because the child's the soul is located in the door. They believe that cooking on the stove or knocking on the door could damage the soul of the fetus and affect the outcome of the birth. Failure to conform to this traditional belief is a frequent explanation of the Yiu-Mien for still births or for the birth of children with a developmental disability or handicapping condition of any sort.

Unfortunately, few SEA-Americans or other health professionals are being trained to cross culturally deliver services to the SEA-American population or other minority groups who have a family member with developmental disabilities. This is attributed to a lack of graduate trainees who are SEA-American or Asian-American and to inadequate multi-cultural models for training individuals to deliver services in other than a standard method.

The health behaviors of the SEA-American population are influenced by their cultural heritage, religion, economics, the type of health services available in their native country, their location prior to entering the United States, the point in time that they entered this country (e.g. first-, second- or third-wave), and their age when they entered the United States. These factors need to be understood in order to work effectively with the SEA-Americans and to provide services for the SEA-American families with a child that has a developmental disability. As Chan (1987) has indicated:

> **In addition to obtaining accurate community data and developing trust by working with indigenous peoples, we must also be knowledgeable about the culturally relevant belief systems and practices of the communities being served. Among such areas of consideration are: the basic philosophy of world view that the various ethnic groups tend to maintain; the corresponding languages and religions that are practiced; the family socialization and child rearing strategies observed; and the traditional concepts of health, mental health, education and family that are followed. We're concerned, too, about the traditional coping strategies, patterns of help-seeking, natural support systems that families utilize, and their styles of interaction with existing providers and services (p.24).**

The ideal situation would be to have SEA-American professionals who have a first-hand knowledge of the SEA cultures to serve as role models for professionals who are Anglo-American or members of other minority populations working in the field of developmental disabilities. However, as previously indicated, there are few SEA-American professionals in these fields.

GENERAL CHARACTERISTICS OF THE SEA-AMERICAN POPULATION

Many of the customs and traditions practiced among the SEA-Americans differ significantly from what is considered "the norm" in this country. SEA-Americans have behavioral expectations of themselves that are unique and quite different from the accepted norms of behavior and attitude in this country. Western manners generally are considered rude, impolite, and even barbarian.

Outlined below are some of the general characteristics of the SEA-American population which Tan (1987) and Chan (1987) have discussed. These characteristics include non-assertiveness, embarrassment from praise, and "loss of face." Other issues covered in this section are religion, diet, the role of the community leader, and the role of the family.

Non-Assertiveness. Western society tends to highly value assertiveness and competition. The origin of this concept comes from western philosophic tradition. It is reflected in our language by phrases such as "man against nature" and the "struggle of life." Many Americans are very direct in their conversations and interactions with other people. They tend to look other individuals straight in the eye and "play to win."

The Asian or SEA philosophy is that of an indirect, cooperative approach to inter-personal relationships. For example, looking at another person directly in the eyes is to threaten an individual and may be considered "barbaric." A non-assertive position is taken to accomplish goals as a group and as an individual. Directly asserting oneself over another person or confrontation is not within the tradition of the SEA-American population and would most likely be considered rude. Tan (1987) uses the example of a boss interacting with an SEA-American employee. In the example, the SEA-American employee asks for some guidance or direction relative to his work.

Instead of answering the question, the boss responds, "That's why we hired you (to figure it out)." Such a response is considered rude and threatening. The SEA-American has sought help, but no help or guidance was received. The result might be that the SEA-American employee will continue to do his or her job but never ask another question again.

Praise. Many employers use praise as a means to reinforce good work behaviors, to motivate their employees to be more productive, or to encourage employees who are engaged with difficult tasks. The SEA-American employee, in contrast to the accepted norm in this country, would be embarrassed to be singled out for commendation and to have others show emotion or praise toward them in public. Praise has another possible interpretation among SEA-American employees (and students). A person who is from one of the SEA cultures may think that the praise was given because that was the only time he/she did something correctly and that the other tasks were performed inadequately or incorrectly.

Loss of face. Loss of face occurs when something is wrong and one is criticized directly. In western society, individuals are encouraged to accept criticism and feedback from others as part of one's personal growth and development. Direct criticism of an SEA-American employee can cause him/her to lose pride in their job and to affect the person's overall sense of self worth.

One major influence of the French-Asian school style on families was the concern for academic achievement. The failure of courses often was considered equivalent to failing the entire school year. A poor grade or failure in one course continues to translate to a "loss of face" for the families of many SEA refugees (Bliatout, 1989). This attitude within a SEA-American family or community can place a great deal of stress upon an SEA-American student. For example, failing a college entrance exam may cause so much loss of face that an individual might try to commit suicide.

Diet. Diet is another area where there differences among ethnic groups within the SEA-American population. Generally, rice and vegetables are the main staples and protein is used more like a condiment. This is very different from the average western diet. The Hmong people have a lactose intolerance and react negatively to milk and milk products. (Doutrich and Metje, 1988). Other SEA sub-populations also have lactose intolerance.

Religion. The religious heritage of the SEA-American population varies from Buddhism, Taoism, and Confucianism to Christianity and to various combinations of these religions. The cultural heritage is that of the traditional eastern religions; Christianity is a twentieth century addition. The beliefs of the SEA-American population center around the traditional values that have been taught and handed down from one generation to the next. Ancestor worship or respect for the family is an important aspect of their belief system and elders within the community are highly respected and often perform leadership roles within the community.

Religious beliefs tend to be tightly held and they have played a major role in the ability of the SEA refugees to adjust to their new lives in this country. Ladkinsky, Kuehn, and Levine (1982) have presented a brief overview of how religious traditions influence health beliefs and behaviors related to health care. Sickness or illness is generally explained in one of three ways — naturalistic, supernaturalistic, or metaphysical. Under the naturalistic concept, the disease or illness is thought to be caused by something tangible, such as bad food or water. Treatment would therefore include the use of traditional herbal medicines and therapeutic diets. In the supernaturalistic view, the disease is considered to be a manifestation of supernatural powers, such as the wrath of angry ancestors. To treat the illness, a clan leader prays for the spirit's forgiveness. In the metaphysical view, the sickness is considered to be the result of evil done by an enemy, and the treatment must be obtained through a shaman who understands the source of the evil and can overcome it.

The Role of the Community Leader. The respect for community leaders, elders, and/or shaman (religious leaders) comes directly from the traditional religious background of the SEA-American population and their emphasis on ancestor worship. The community leaders were very influential in their community in Asia and continue to be so in this country today. For example, if a Hmong person goes to a western doctor and the doctor recommends a treatment plan, the individual will usually consult his/her community leader before following the plan. If the leader has no direct knowledge of the condition or no understanding of the treatment plan, the community leader may recommend that the individual not follow the treatment plan. Most likely the Hmong person would follow the recommendations of the leader instead of the western physician. In the Hmong community, the role of the leader is authoritarian and not one to be questioned.

Among other SEA-American populations, the role of the community leader is usually not as influential. However, there are recognized leaders within each community of SEA-Americans, and the opinions of these leaders regarding finances, health, education, and so forth is highly valued. The community leaders are significant individuals, especially for smaller communities. The influence of the community leaders can make a significant difference to the successful development and implementation of a recruitment program for trainees or of a community service program.

Family. The role of the parent (usually the father) as head of the household follows the same tradition as that of the community leader. Parents or the elder male in the house have significant control over the immediate family and often the extended family group. While this influence has been lessened as the SEA-Americans acculturate themselves to the more western values and traditions, the role of the parent relative to health and education decisions is very important and can not be ignored.

Tan (1989) noted that Cambodian families within the SEA-American population are changing in this regard. Wives are learning more about financial freedom as they enter into the job market. These women no longer follow the exact directions given by their husbands and there appears to be more respect for women as individuals. However, Tan (1989) has suggested that these attitudinal shifts may account for the fact that the divorce rate among Cambodians has changed from the four percent it was in Cambodia to the 40 percent it is in this country today.

In the western traditions, the family is composed of parents and children and the extended family is composed of grandparents, the siblings of parents, and their cousins. The concept of family is very different for the SEA-American population. Bliatout (1989) explained that as a child he grew up in a household of 41 family members. This family was supported by one income. The family included grandparents, parents, children, the parents' siblings, and the siblings' children. Non-family members (not blood, not adopted) of the family are often treated and included as members of the family.

The size of the family is important in several respects. Historically, many children were needed so that some of them would survive to support their parents in old age. Additionally, many individuals were needed to work in the fields, on farms, or in the family business.

The family units of the first-generation Americans tend to be smaller as western traditions and the economic realities of living in the United States influence the SEA-Americans. However, it is still not uncommon to find multiple generations and families living together or in close proximity to one another. The grandparents' role in families is very important as teachers of tradition and culture.

The extended family serves many purposes. It is the support network for the care of the family and for assistance with health, education, and economic issues. Support for a child comes from the family whether that child has a developmental disability, is normal or gifted, or has a special health condition or a learning problem. Thus, the family fills the role of the social services network.

EXEMPLARY RECRUITMENT AND RETENTION APPROACHES/PROGRAMS

As health professionals continue to try to meet the new service demands, a valid criticism is raised as to why health profession schools have so few Asian-Americans entering the fields of health, allied health, and the social services. In general, efforts during the past two decades to increase minority students in these fields have had a minimal impact upon SEA-American students. Also, these efforts have not resulted in additional minority students entering the UAP training programs. Acker, Freeman, and Williams (1988) cite two methods that have been used to increase the number of minority students in the health sciences. These are:

- initiating programs to increase the interest of minority adolescents in the health sciences, and
- financial, educational, and social supports for minority students in those programs.

These types of programs need additional components to motivate SEA-American students to enter the fields of health, allied health, or the social sciences and subsequently become available for UAP training programs. The recruitment of SEA-American students into UAP training programs will take many years. There is no "easy or quick fix" to the problem.

The program outlined below is intended as a guide that UAP administrators, faculty, and program staff can use to develop their own individualized plan to recruit and retain SEA-American students. It has eight main components which can be addressed sequentially or concurrently.

They are:

- outreach to SEA-American community leaders,
- identifying prospective SEA-American students,
- outreach to SEA-American parents,
- high school interest program,
- college application strategies,
- financial, educational, and social supports for undergraduates,
- support systems for graduate students, and
- stipends to for SEA-American interns and fellows.

Prior to implementing a recruitment and retention program, Cross (1988) has suggested that universities need to prepare the faculty and to assess the curricula to ensure at least a basic level of cultural competence. This preliminary step would also be critical to the successful implementation of a UAP recruitment and retention program.

Step 1 - Outreach to SEA-American Community Leaders. No program will be successful recruiting and retaining SEA-American students unless the program staff work directly with the SEA-American community leaders. The SEA-American community leaders can be identified formally through the Mutual Assistance Associations (MAAs). Many of these programs are listed in the telephone book, but if you do not know the names of the MAAs in your area, contact the federal Refugee Data Center. Additionally, refugee health clinics are often operated by the county health departments in larger communities and are avenues to access SEA-American community leaders.

The first contact with the SEA-American community leaders may be through a liaison with the MAA staff or other individual contacts. Reach out to the SEA-American community leaders by setting up a meeting at the MAA or at one of the businesses of the SEA-American leaders. (Be sure that a translator is available.) This contact should be to explain the need for SEA leadership in the health, allied health, and social service fields. In particular, one should address the need for

SEA-Americans in the field of developmental disabilities. Through this dialogue, you will be providing important information regarding the structure of the western health care system and how the participation of SEA-Americans are needed to provide services, to teach, and to do research.

The more isolated and rural the SEA community is in this country, the less contact they will have had with our cultural institutions and values. Their values and community will be more similar to those that existed in their native country. Several liaison meetings may be necessary to show the value of their children going into the health, allied health, and social service fields. The community leaders usually become interested in helping and will cooperate in whatever is necessary, if adequate explanations and time are given.

The next phase is to invite the SEA-American community leaders to see your UAP and the types of services that are offered to all. They could see professionals and students participating in clinical training, field placement programs, client evaluations, and a variety of other service activities that could be utilized by the SEA-Americans. The cultural bridge is not complete, however, if the community leaders do not recognize the value of their SEA culture(s) for the provision of better services for SEA-Americans and for other Asian-American families with a child or adult who has developmental disabilities.

Step 2 - Identifying Prospective SEA-American Students. Identifying prospective SEA-American students will require working with the SEA-American community leaders and local school systems. A joint effort between the UAP faculty and the SEA-American community leadership could be initiated to identify children even in elementary school who have great potential and who might drop out unless adequate support is given. This will require universities and UAPs to commit to a long-term effort which also will involve other minority groups.

Step 3 - Outreach to SEA-American Parents. SEA-American parents have a significant influence upon their children. Most children will honor the requests of their parents. In order to comply with the cultural value system, the parents of the children and students need to be approached first.

After the general meeting with the SEA-American community leaders, they may be willing to contact the parents of the children who are prospective students. Or, the community leaders may introduce you directly to the parents. When meeting with the parents, the opportunity and value of the educational program should be imparted along with the potential career opportunities for their child. The mechanisms of support -- educational, financial, and social -- must be explained and further discussion may occur at a second meeting between community leaders, parents, and university staff.

Step 4 - High School Interest Program. Many universities have an adolescent interest program for minority students in high school. One approach to early intervention which has been used in many cities is that of creating a high school for the health professions. For example, the Houston (Texas) Independent School District and Baylor College of Medicine initiated its High School for the Health Professions, which is a model program that has been replicated in many states. When the program began in 1972, 45 students attended classes on the Baylor campus (Thomson, 1984). The program now has a total enrollment of 750 students (43% African-American, 33% Hispanic, 20% Anglo-American, and 4% Asian-American). This program combines a comprehensive academic curricular program for grades nine through twelve with specific learning experiences designed for health-related professions. Approximately 600 students apply for admission each year, and 200 are accepted based on previous academic performance and teacher recommendations. Eighty-five percent of its graduates attend college. (Hickey and Solis, 1990).

Such programs could be widened to include allied health, social services, and other professional training programs. Another type of programs would be a mentor program where one faculty member works to support a promising student on a one-to-one basis. Programs that include tours, field trips, seminars, and/or practice experiences could be effective for recruiting members of all minority groups. accomplished.

Step 5 - College Application Strategies. Secondary schools and SEA-American community leaders need to develop a strategy to assist high school students with the application process. Both SEA-American parents and the potential SEA-American college student need to be assisted to apply to more than one school. Until the SEA-American families and community leaders learn that being rejected by one school does not mean that they will be rejected by all, many promising SEA-American students will not matriculate into college.

There are a variety of programs that have been developed to assist minority students with the application process. Hickey and Solis (1990) have described a the Med-COR program which involved the parents of potential students. The parents met once a month and were encouraged to become involved in the educational process with their children. The parents also were provided with workshops on the college application process, health career opportunities, financial aid, and study skills. A total of 480 students took part in Med-COR over a five-year period (1973-1977) and 410 (85%) completed the full three years (93 percent of the dropouts were in the 10th grade). Of the 410 graduates of the program, 240 responded to a follow-up questionnaire in 1980. The results of the survey indicated that two (1%) completed medical school, fifteen (6%) were in medical school, six (3%) were in dental or pharmacy school, twenty-one (9%) were enrolled in non-health related graduate programs (primarily engineering and business), and 188 (78%) were undergraduate college students (88 premedical, 37 pre-nursing, 10 other allied health fields, 29 non-health related majors, and 24 undecided). Although the findings of the Med-COR evaluation

must be interpreted with caution because of the follow-up response rate of 59 percent, the findings support the view that programs focusing on early academic intervention during high school are effective for increasing the number of minority health professionals.

In addition to the development of special programs for high school students, universities need to move beyond simple quota systems and admit as many qualified students as possible. Quotas are important, but when they are used to block additional minority students rather than as a goal to be achieved, they are working in reverse of their intent (Moore, 1989).

Step 6 - Financial, educational and social supports for undergraduates. The costs of higher education are exceeding the ability of students and families to pay. If qualified SEA-American and other minority students are to continue their education, universities or state governments need to appropriate funds to keep the qualified minority students in school.

The financial aid packages for SEA-American and other minority students need to take into consideration the extraordinary financial constraints on the student's family. For example, some of the SEA-American students contribute to the support of their families. This income could make a difference in the attitude of the SEA-American family to allow their child to go onto higher education. Additionally, many of these families are making great sacrifices to bring other family members to this country or to send money back to their families in Cambodia, Laos, or Vietnam. This may mean that the income level of the family is not adequate for the normal support of a student in higher education because a significant portion of the family's income is being used to reunite the family or to provide assistance to their elders who are 20,000 miles away.

Educational support is needed to assure the adequate performance of SEA-American students in coursework. This may take the form of tutors or organized study groups. In addition, the director of

minority student affairs or the student's advisors need to be aware of potential and actual problems related to the retention of SEA-American students.

Social support is also necessary. SEA-American students tend to be reserved and studious. They feel isolated in programs and do not enter into the social system in colleges. In these instances, advisors or minority student programs need to establish ways that will socially involve students and integrate them into the mainstream of programs and social events on campus.

Step 7 - Support Systems for Graduate Students. A similar support program to that of the undergraduate program described above needs to be established for graduate students, including UAP trainees. This would include financial, educational, and social supports.

Step 8 - Stipends for SEA-American Interns and Fellows. SEA-American students will need a financial commitment to attract them to spend additional time in training. Internships and fellowships need to be available and reserved for SEA-American interns and other minority students. Special funds could be made available by working with the SEA-American community leaders to attract SEA-American students back to their own community.

Summary. SEA-American students and other minority students could all benefit from the program described above. Unique to SEA-American students is the need to promote health, allied health and social services careers within the SEA-American community. Additionally, approaching the family first is not the usual manner one follows to recruit students. However, the influence of the family and community leaders is necessary to begin attracting SEA-American students. Only through such programs will there be a pool of graduate students from the SEA-American community for UAP training programs and to work with children and adults with developmental disabilities.

EXEMPLARY PROGRAMS

Southeast Asian Developmental Disabilities Prevention Program
(CEDE or CEDE-II)

Target: Community developmental disabilities services for the SEA population from 0 to five years of age.

Contact: Dorothy M. Yonemitsu, LCSW, Programs Director
1031 25th Street
San Diego, CA 92102
(619) 235-4270

The CEDE or CEDE-II Prevention Program is a model community based service program to deliver culturally and linguistically appropriate services, to facilitate client access to existing services and to link clients to a comprehensive service network. The CEDE program, now CEDE-II, is a collaboration between the San Diego Regional Center which provides services to individuals who are developmentally disabled and the Union of Pan Asian Communities (UPAC). The UPAC program provides comprehensive generic service programs for the SEA population in the San Diego area.

The CEDE addition to UPAC is a logical marriage to bring the developmental disabilities services to the SEA communities. The initial effort concentrated on the birth to age three population for early identification and intervention. This successful effort trained community members to provide services for their community. The CEDE program just received a second grant for the CEDE-II program from Maternal and Child Health to expand their services to the age of five years. The efforts of the CEDE program have brought a new understanding of developmental disabilities to the SEA population of the San Diego area. CEDE provides services and a unique opportunity as a practicum site to learn the diversity of a multi-culturally based service model. In addition, training individuals from the SEA community to provide direct services is seen as a contribution to the growing field of developmental disabilities.

The SEA-Americans who provide the services and coordinate activities for this program were selected from their local community and trained to do specific tasks. In most cases, they are performing and modeling a service delivery system as any other professional or trained individual would do. While it is recognized that they cannot take the roles of licensed individuals, they are qualified service providers who were trained on the job.

This program establishes a career ladder and offer opportunities for advancement. The SEA-Americans are given the respect they have earned by other professionals and they are considered as professionals or career individuals. This method of having SEA-Americans trained to fill an immediate does not lock them into only clinical or client work, but allows them to advance into leadership roles (Yonemitsu, 1989; Nakama, 1989).

Multicultural Training and Education Program Children's Hospital

Target: Undergraduate and graduate students

Contact: Sam Chan, Ph.D.
Center for Child Development and Developmental Disorders
Children's Hospital of Los Angeles
(University of Southern California)
4650 Sunset Boulevard
Los Angeles, CA 90027
(213) 669-2300

The University of Southern California's UAP at Children's Hospital is noted for their efforts and directions in recruitment and retention of minority students. Their efforts involve training of faculty in cultural sensitivity, active recruitment of minority students and working to keep the students once they are in the program. Each year the faculty set a minority recruitment goal. This year the goal is that 40% of all long term trainees (300+ contact hours) will be from minority populations. Special emphasis is placed on Asian-American and Hispanic-American students. The faculty reach out to find and attract the minority students into their program. This requires extra efforts being spent in recruitment of students each year.

The UAP training program itself addresses issues corresponding to previously detailed demographic trends among ethnic populations. UAP trainees are systematically exposed to information and experiences pertaining to the delivery of services to ethnically and culturally diverse clients and families.

Some specific content areas planned for the curriculum now being developed include:

- the nature of basic cultural orientations and values among selected ethnic minority groups;
- traditional views toward various aspects of child development;

- parental expectations regarding academic achievement;
- the use of appropriate (non-biased) assessment instruments and procedures for culturally and linguistically diverse exceptional students; and
- parent views of handicapping conditions and coping styles.

A great deal of the material being developed was gathered through the "Multicultural Training Of Trainers (MTOT) project funded by OSERS. Samples of the MTOT materials are available upon request.

Child Development and Retardation Center
Oregon Health Sciences University (OHSU)

Target: Undergraduate and graduate students

Contact: John Keiter, Ph.D. or Gerald Smith, Ed.D., UAP Director
Child Development and Rehabilitation Center
Oregon Health Sciences University
P.O. Box 574 (707 SW Gaines)
Portland, Oregon 97207-0574 (97201)
(503) 279-5688 or 279-8364

The Portland University Affiliated Program is an integral part of the Oregon Health Sciences University and the Oregon Services for Children with Special Health Care Needs (SCSHN), Title V program. The Portland UAP is involved in the outreach to minority families and their disabled children across the state. The UAP serves as an integral link to establishing culturally appropriate services through liaisons with community providers.

In particular, a Liaison Educator's Grant is funded by the Oregon Department of Education and the CaCoon Program, funded by the SCSHN program provide linkages back to the communities. Children are often referred by a variety of sources for assessment and development of intervention programs to this center. Few, if any community staff come into the center. Thus, it is the responsibility of the Liaison Educators and CaCoon staff to link back with the local agencies to assure that culturally appropriate and adequate services are available to meet the child's needs. These activities link the communities together with the UAP and SCSHN programs being a hub for the state.

The Oregon Health Sciences University has developed a minority recruitment program in order to encourage the few minority students to seek their education in state. The Mentorship program seeks out promising high school minority students through cooperation with the local school districts. These students are invited to join the Mentorship Program after an initial visit to the campus. The full program involves attending lectures, special seminars, work experiences and a one to one relationship with a faculty member that encourages the

consideration of a health or allied health career. Some of the UAP faculty serve as mentors in this program.

The Portland UAP has benefited from the Mentorship Program in becoming more culturally sensitive to ethnic minority clients, students, and professionals. Cultural sensitivity training has been provided by Terry Cross and others as part of the on-going Interdisciplinary Forum required of all long term trainees.

OHSU pediatric medical students and nursing students have a required rotation in their curriculum that brings them to the UAP. As the number of minority students has risen at the OHSU, the UAP has had larger numbers of minority students. In addition, the UAP actively recruits minority interns and fellows from across the country. The Portland UAP has few stipended trainees; however, the program has been able to attract outstanding long term trainees from various minority groups and from around the world. The demand for minority trainees is growing and it will be increasing harder to draw these minority trainees unless stipends are available.

APPENDIX

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